Matter of OSHA Emergency Temporary Standard

Comments on the ETS and the Inaction on Docket Number 2020-0004

By Theo Allen

I. Introduction

I have made multiple submissions on the healthcare emergency temporary standard which I incorporate by reference[1]. Those include

- Initial comments submitted on June 21, 2020 that set forth grounds for relief and a request for a hearing as provided by Federal Law.
- Comments submitted which forced the leaked draft emergency temporary standard to be published in the Federal Register
- Final comments submitted on August 20, 2020 that included a comment that OSHA was required to implement a vaccine mandate for COVID-19 for all workers and included a model airborne pathogen disease rule for OSHA to consider.

This emergency temporary standard is an attempt to get around the requirements to hold the hearing that I demand OSHA hold pursuant to 29 U.S.C. §657(b)(3). The emergency temporary standard is unlawful and OSHA should convert the healthcare standard into a final rule as proposed therein.

[1] The docket numbers that are incorporated in their entirety are specifically docket numbers 1034 and 1468. I also submitted docket number 1106, which placed the draft ETS into the record. I do not incorporate docket number 1178 by reference.

The courts of appeals and the Supreme Court reviewing the emergency temporary standard should, in light of my submissions, order OSHA to forthwith hold a formal virtual hearing on the healthcare emergency temporary standard that I requested on June 21, 2021, pursuant to section 6(b) of the OSH Act, then to issue a final rule within sixty days of that hearing being concluded. Pending such action, this rule should be modified by invaliding the 100 employee exemption as well as the federal contractor and healthcare worker exemptions from subpart 501, and remove the weekly test in lieu of mandatory vaccination option.

Furthermore, I demand a public hearing (and not secret special interest meetings at the Office of Management and Budget with lobbyists) be held, as required by Federal Law, be held on the emergency temporary standards and proposed rules as soon as possible.

II. OSHA Questions

A. 100 employees

OSHA has stated the following:”The agency is moving in a stepwise fashion on the short timeline necessitated by the danger presented by COVID-19 while soliciting stakeholder comment and additional information

to determine whether to adjust the scope of the ETS to address smaller employers in the future."

The danger from covid-19 need not be answered in a stepwise function, unless OSHA is concerned about the ability to implement a vaccine program. Such a mandate is feasible and provides cost benefits to employers, as described on page 131 of the August 20 submission[2] where I described how for a worker making fifteen dollars an hour working forty hours a week, the vaccines would save the employer $68 if retained for three months, so I concluded vaccine mandates are feasible. Since I concluded that a vaccine mandate without testing and masks are appropriate, I decline to comment on the cost benefit analysis of such policy.

B. Significant Risk Standard

On significant changes if a permanent standard are made, I do not see a significant difference between what I submitted in the August 20 submission and today. This is because the tools that can stop COVID-19 did not change and other airborne pathogens are blocked by similar means. Furthermore, I already commented on that proposal extensively.

[2] https://downloads.regulations.gov/OSHA-2020-0004-1468/attachment_1.pdf

Due to the mandatory 30 day notice and comment period before changing mask standards, I have taken the position that OSHA should **not** directly impose an unconditional mask mandate in a final rule on COVID-19. OSHA should use consultation between workers and employers or tie masks to rates of respiratory illness, similar to what Nevada has done.

C. Prior COVID-19 Infection

OSHA has asked about workers who had a prior infection. I would suggest following the CDC guidance. While I commented on page 140 in my August 20 submission that one dose of the COVID-19 vaccine after infection should count as fully vaccinated, I would recommend deferring to CDC guidance. I have recommended such guidance follows CDC criteria or be listed in a separate section that can easily be updated by OSHA as the scientific knowledge progresses. As stated on page 135 of my August 20 submission, “I designed this [model airborne pathogen rule] in an attempt to be transparent and allow OSHA to implement a model to expand this to all airborne pathogens”.

On page 140, I specified that one dose plus a prior infection should count as fully vaccinated. While I believe that it will eventually be three doses, the rule that should be implemented should allow appropriate dose spacing.which is significantly longer than the three or four weeks, or around two months.[3]

If using rapid tests, which determine infectiousness, and face coverings, it is feasible to implement such requirements. The question that should be asked is whether prior infection is as effective as vaccination. A CDC MMWR said that the vaccine is about 5.5 times more effective at stopping hospitalizations compared to prior infection.[4] This is not an area where it is less feasible, but a question about the science.

As to any such test, the FDA and CDC have not determined that such limits can be used to protect against reinfection. However, in Europe, a common rule is that recovery is valid proof of immunity for six months.The CDC has also published this in their scientific reports.[5] Furthermore, Israel is using an anti-N test for immunity.[6] Such an exception can exist as a matter of public health. However, it should be repeatedly stressed that

[3] Canada Sees Benefits From Delaying Second Vaccine Dose (voanews.com)
[4] Bozio CH, Grannis SJ, Naleway AL, et al. Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19–Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity — Nine States, January–September 2021. MMWR Morb Mortal Wkly Rep. ePub: 29 October 2021. DOI: http://dx.doi.org/10.15585/mmwr.mm7044e1

[5] Science Brief: SARS-CoV-2 Infection-induced and Vaccine-induced Immunity | CDC
[6] Israel recognizes 'anti-N' serology test for COVID Green Pass eligibility - Israel News - Haaretz.com

immunity through infection is very dangerous and highly unethical. The consequences of death, hospitalization, long covid, and various other harms that COVID-19 causes make it unacceptable to encourage infection for natural immunity.

D. Mandatory Vaccination Policy

OSHA has asked should it implement a mandatory vaccination policy. As stated in my August 20 brief, I concluded on page 114 that OSHA is required by section 6(c) of the OSH Act to mandate vaccination for all workers without alternative compliance options..

Some questions include when it should be implemented, and I answered as soon as possible. The vaccines need to be mandatory because of the benefits of vaccination.

The next question is vaccine access. As stated by Doctor Julia Raifman, having paid time off and transportation reimbursed (if not on site) to get vaccinated is needed for many workers and on site vaccination centers help with access to get vaccinated.[7] Vaccination mandates are needed to boost vaccination rates, and 99% of workers can be expected to

[7] State policies can provide clear guidance on when to put on and take off masks – with benefits to health, education and the economy (theconversation.com)

get vaccinated when such mandates are implemented.[8] Furthermore, the vaccine mandate should include recovery time if needed for the vaccines.

I did not address vaccine verification or attestation, because I view the method of ensuring vaccinations have occurred to be adequate for the employer. Furthermore, falsifying records is employee misconduct.

OSHA asked if vaccination decreases infection rates or outbreaks, and based on the science, the expected answer is yes. And they ask about accommodations for workers who refuse to get vaccinated. As stated elsewhere, I recommend that the vaccines be mandated and that accommodations are not appropriate if someone has a legal exemption, such as requiring telework or face coverings.

E. Testing

If OSHA arbitrarily and capriciously allows testing in lieu of vaccination, employers should not be required to pay for such tests. Furthermore, given the accuracy of at home rapid tests at detecting infection, such policies should be clear that those tests can work. If someone tests positive, the same protections that I recommended for workers being required to stay home as specified in Section VIII-B-5 of my

[8] One percent of adults say they've left job due to vaccine mandate: KFF poll | TheHill

August 20 submission. Paid leave for testing in lieu of vaccination should not be required, not such activities considered working.

F. Face Coverings

In terms of face coverings, I specified when they are required due to high spread, that a barrier face covering meeting ASTM level F3502 standards, medical mask, or respirator must be offered by the employer to the employee but the employer is not required to ensure that the employee wears it. I continue with that recommendation. Face coverings are not adequate protection to prevent inhalation of SARS-CoV-2, but they are effective. I favor requiring a well fitting mask due to the importance of fit against aerosols.

G. Other tools

I would like to comment on other tools. Ventilation improvements are appropriate and distancing helps. Ground 7 in June 21 discussed that barriers are not a tool that helps (and can actually harm) stopping COVID-19. Due to the mode of transmission, sanitization is not effective at stopping covid and can cause toxins to be generated. Physical distancing does help, however.

H. Educational Resources

While I do not have full educational resources available, due to the disinformation being spread by the CDC's Project Firstline, the tools they developed should not be used or recommended. Project Firstline has continued to deny airborne transmission of COVID-19, Project Firstline focuses on respiratory droplets instead of aerosols and says negative pressure is only needed for "aerosol generating procedures", among other things. They continue to claim that changing N95 masks or respirators should occur after leaving the patient room, despite that being worse in terms of infection control.[9] And in their October 6 livestream[10], they did not discuss vaccination. CDC's Project Firstline is unreliable and OSHA should not recommend such materials.

I. Feasibility and Health Impact

It is clear that mandating tools to stop the spread of COVID-19 will save lives. Using vaccines has minimal costs and is recommended by all

[9] MacIntyre CR, Chughtai AA, Rahman B, Peng Y, Zhang Y, Seale H, Wang X, Wang Q. The efficacy of medical masks and respirators against respiratory infection in healthcare workers. Influenza Other Respir Viruses. 2017 Nov;11(6):511-517. doi: 10.1111/irv.12474. Epub 2017 Aug 30. PMID: 28799710; PMCID: PMC5705692.

[10] CDC's Project Firstline - Project Firstline Virtual Discussion and Q&A | Facebook

economists participating in a survey at the Initiative on Global Markets at the University of Chicago.[11]

III. Legal Standard

The same legal standard applies to the OSH Act applies to both ETS standards. Accordingly, my August 20 submission, Section III, provides the appropriate legal standard. One fact that OSHA has claimed is that workers can be required to pay for an inferior protective measure (vaccines or tests). Allowing an inferior standard violates 29 U.S.C. § 655(b)(5) which requires setting the standard which "most adequately assures … that no employee will suffer material impairment of health or functional capacity even if such employee has regular exposure to the hazard…". If the masks and tests are inferior at assuring this harm will not occur to vaccines, then the option is illegal.

IV. Rational for the ETS

A. Grave Danger

OSHA stated at the conclusion of section III-A-I of the proposed ETS the following:

[11] Vaccine Mandate - IGM Forum (igmchicago.org)

“Published on June 21, 2021, OSHA’s Healthcare ETS (86 FR 32376) was written in response to the grave danger posed to healthcare workers in the United States who faced a heightened risk of infection from COVID-19. In the healthcare ETS, OSHA described its finding of grave danger for healthcare and healthcare support service workers (see 86 FR 32381-32412). OSHA now finds that all unvaccinated workers, with some exceptions, face a grave danger from the SARS-CoV-2 virus”

This grave danger being limited to healthcare and healthcare support workers The acceptance that this applies to unvaccinated workers should be constructed as a concession that Ground 1 that I specified on June 21, 2021 standards. In other words, OSHA should be deemed to have admitted that the distinction between healthcare and other workers was, and is, arbitrary and capricious, and not supported by substantial evidence. However, OSHA declines to do so.

B. Variants

OSHA attempts to defend this based on variants that are occurring. While OSHA tries to base this off the “Delta” (B.1.6.1.7) variant, this vactor did not change the fact that workers were at grave danger before the variants of concern. The difference is that because the variants are more

transmissible, vaccines alone are not enough. This is a public health issue, and the abdication of public health has been a major concern.

C. Transmission

OSHA describes the CDC as describing respiratory droplets spreading the virus and airborne transmission sometimes occurring. They state in section III-A-II-b the following:

“According to the CDC, the primary way the SARS-CoV-2 virus spreads from an infected person to others is through the respiratory droplets that are produced when an infected person coughs, sneezes, sings, talks, or breathes (CDC, May 7, 2021). Infection could then occur when another person breathes in the virus. Most commonly this occurs when people are in close contact with one another in indoor spaces (within approximately six feet for at least fifteen minutes) (CDC, August 13, 2021). Additionally, airborne transmission may occur in indoor spaces without adequate ventilation where small respiratory particles are able to remain suspended in the air and accumulate (CDC, May 7, 2021; Fennelly, July 24, 2020).”

I renew my objection in ground 2 set forth on June 21, 2021, against the denial of airborne transmission, against such arguments.

D. Impact on Workplace

In section III-A-III, ISHA describes the driving factor was the disproportionate risk to healthcare workers, As stated on pages 8-11 of my June 21, 2021 submission, part I-B, this risk from suspected or confirmed cases is limited to denying the virus is airborne. Ground one specifies that healthcare (and healthcare support) workers are generally at lower risks compared to essential workers of getting COVID-19. OSHA makes the following statement in Part III-A-III of the ETS.

“The basis for OSHA’s grave danger finding is that employees can be exposed to the virus in almost any work setting; that exposure to SARS-CoV-2 can lead to infection (CDC, September 21, 2021); and that infection in turn can cause death or serious impairment of health, especially in those who are unvaccinated (see Section III.A.IV. Vaccines Effectively Reduce Severe Health Outcomes from and Transmission of SARS- CoV-2). The information described in this section supports OSHA’s finding that employees who work in spaces shared by others are at risk of exposure to SARS-CoV-2. The degree of risk from droplet-based transmission may vary based on the duration of close proximity to a person infected with SARS-CoV-2, including the Delta variant, but the simple and brief act of sneezing, coughing, talking, or even breathing can significantly increase

the risk of transmission if controls are not in place. SARS-CoV-2, including the Delta variant, might also be spread through airborne particles under certain conditions, particularly in enclosed settings with inadequate ventilation, which are common characteristics of some workplaces."

As has been stated in ground 2 of the June 21, 2021 objections to the healthcare emergency temporary standard and on pages 64-69 of the August 20, 2021 submission, the virus spreads via the airborne route. Furthermore, that some workplaces are enclosed settings with inadequate ventilation means those workplaces have heightened risks of spread.of the virus.

To the extent that OSHA is now admitting that outbreaks occur in a variety of settings, this should be a concession that the draft ETS was correct in its finding and my objections in ground 1 of the ETS submitted on June 21, 2021, were valid objections.

E. Coverage

OSHA in sections III-A-V excludes from this scope several groups. Some of these exclusions are supportable by substantial evidence, and consequently, should be upheld. The work from home or telework exception

is an exemption I identified in the August 20, 2021, submission on page 138.

OSHA has described workers who work exclusively outdoors as exempt from the ETS. While I did not include such exclusion in the ETS, this sort of exclusion is defensible and can be supported in my submissions[12]. This is further consistent with Ground 9 of my June 21, 2020 submission. However, the reasoning for the outdoor exclusion is inconsistent with droplet transmission. The fact that the virus is airborne (which has been denied by OSHA without substantial evidence to support that conclusion) shows why the ventilation outdoors is incredible.

However, in excluding healthcare workers, OSHA pretends that the precautions in healthcare settings do not require vaccine or testing. The healthcare emergency temporary standard that OSHA intends to let expire in December of 2021[13] does not require healthcare workers to get vaccinated or undergo weekly testing. Furthermore, as stated on pages 112-116 of my August 20, 2021 submission.

[12] Sullum, J. (2021, May 26). *An epidemiologist confirms that the CDC Director Misrepresented her study of Outdoor Covid-19 Transmission. Reason.com.* https://reason.com/2021/05/26/an-epidemiologist-confirms-that-the-cdc-director-misrepresented-her-study-of-outdoor-covid-19-transmission/.

[13] Under 29 U.S.C. §655(c)(2), that standard remains in place until a permanent standard is imposed.

V. Need for the ETS

While OSHA describes the need for the emergency temporary standard. The failure to make a determination as to whether unvaccinated workers in non-healthcare settings were at grave danger was illegal. I attempted to find a justifiable reason, and concluded that none existed. The refusal to make such a determination was a violation of the OSH Act. “OSHA made no finding at that time regarding unvaccinated workers in non-healthcare workplaces

Furthermore, the rise in states imposing anti-public health measures was documented on pages 14-15 and on page 96 of my August 20, 2021 submission, That three states prohibit vaccine mandates for the virus by private employers, which OSHA states are Arkansas, Montana, and Texas, demonstrates why OSHA needs to impose a vaccine mandate for virtually all workers covered by the OSH Act.

While I decline to challenge the findings that the vaccines are the single most important intervention, I disagree that they are enough. Masks also help. However, the finding in section III-B-II of the emergency temporary standard that the vaccines are the most effective method of compliance means that OSHA cannot allow the alternative method to be used in lieu of vaccination. This violates 29 U.S.C. §657(b)(5) which

requires the “most adequately assures” standard to be used. If OSHA believes that the lack of vaccination is what creates the grave danger, then as stated on pages 92-93 of my submission on August 20, 2021, OSHA should only mandate the covid-19 vaccine and do nothing else.

While OSHA says tools other than personal protective equipment should be used, physical barriers as required by OSHA in some cases under the healthcare standard in non-patient care spaces, and under the draft standard more broadly, are actually ineffective at stopping the virus. This was ground seven of my June 21, 2021 submission.

Furthermore, while not requiring vaccination may be traditional, in the context of a pathogen such as covid-19, that rule should not be absolute. The reason for not mandating the vaccine is due to the Presidential statement on September 9 which also mandated federal workers and contractors get vaccinated. The proper approach was for OSHA to be the lead. I called on OSHA to be the hero in mandating the vaccines. The Federal civilian employee[14] and contractor mandates should have flowed from the OSHA requirement. OSHA said “Since it is the lack of vaccination that results in grave danger, vaccination will best allay the grave danger”. The solution is vaccine mandates.

[14] I am excluding the uniformed services (exempt for civilians) in this statement.

As noted, my August 20 submission considered the substantial danger consideration.

VI. Vaccine Mandate

In section III-B-II-a, OSHA describes why it decided to strongly encourage the vaccines. The OSH Act, in 29 U.S.C. §669(a)(5) states "Nothing in this or any other provision of this chapter shall be deemed to authorize or require medical examination, immunization, or treatment for those who object thereto on religious grounds, except where such is necessary for the protection of the health or safety of others." Accordingly, based on such language, the exception means that the authorization to require immunizations regardless of religious or medical exemption.

As the American Public Health Association and others told in an amicus brief to the Supreme Court, no substitute exists for vaccine mandates.[15] Financial incentives do not get people vaccinated.[16] The amicus states influenza vaccination mandates are needed for healthcare workplaces at 90% coverage.[17] It is important to note that influenza is as

[15] 20211028141652778_2021.10.28 - Vaccine Mandates Public Health Scholars.pdf (supremecourt.gov)
[16] Tom Chang, et al., "Financial Incentives and Other Nudges Do Not Increase COVID-19 Vaccinations among the Vaccine Hesitant," NBER Working Paper 29403 (October 2021).
[17] iffany L. Wang, et al., "Mandatory influenza vaccination for all healthcare personnel: a review on justification, implementation and effectiveness," 29 Current Opinion in Pediatrics 00, 4 (2017) ("promot[ion]" of voluntary vaccination at workplaces resulted in vaccination rate under 90%); see also, e.g., Alexandra M. Stewart & Marisa A. Cox, "State law and influenza vaccination of health care

airborne as SARS-CoV-2 is, as expressed by occupational health doctor Donald Milton, and less transmissible compared to SARS-CoV-2. Given these facts, mandating the vaccine is not optional.

Furthermore, while the statute requires religious exemptions for medical examinations, immunization, and treatment, an exception is given "where such is necessary for the protection of others." While only religious grounds were considered, it reflects a policy that OSHA has adhered to a policy of not mandating this when others are not harmed, even on non-religious grounds. For COVID-19, a different policy is appropriate, given that others are harmed by a person who is unvaccinated..

OSHA has decided to preempt inconsistent state statutes as I recommended on June 21, 2021, in change 10 of the emergency temporary standards. I decided, however, that this did not go far enough and a vaccine mandate is needed, instead, in my August 20, 2021 submission.

While OSHA later says "Given that the SARS-CoV-2 virus is highly contagious, transmitted easily through the air, and can lead to severe and/or fatal outcomes in unvaccinated workers, it is critical that employers who do not require their employees to be vaccinated implement controls to

personnel," 31 National Library of Medicine 5, 827-32 (Jan. 21, 2013) ("[O]nly an institutional mandate for influenza vaccination proved to achieve the Healthy People 2020 objective of vaccinating 90% of HCP").

mitigate the potential for COVID-19 outbreaks to occur.", I would point out two things. First, the reason to vaccinate workers is not because of the mode of transmission, as suggested on page 118 of my August 20, 2021 submission.. Second, saying that that the virus is transmitted easily through the air while not saying that the virus is airborne does not make sense. That is contrary to what my submissions suggest. And while OSHA strongly prefers the mandatory vaccination policy, it should implement that policy.

VII. Other Actions Insufficient

I concur that no other agency action short of broad regulation is required. While OSHA uses section III-B-III of the emergency temporary standard to do that, I rely on section IV-B-2 of the August 20, 2021 submission.

VIII. Feasibility

The setting of the 100 person floor was decided for four reasons. The first is that the disruptions for smaller employers have not been considered. Unless OSHA determines that the economic burden of the paid time off and recovery time is so harsh to smaller employers that the burden should not apply, this does not meet the feasibility requirements.

In denying small businesses, OSHA assumes that 5% of workers may have a medical contraindication or seek a medical or religious exemption for a covid-19 vaccine. To be clear, the only exemptions that are appropriate are for medical contraindications, according to the American Nurses Association[18]. The American Academy of Family Physicians also only supports medical contraindications and allergies.[19] The American Academy of Pediatrics only supports medical exemptions.[20]

Given the rarity of a medical contraindication (only certain allergic reactions warrant that), and the fact that neither medical nor religious exemptions should be permitted, those human resources concerns are not grounds for limiting the vaccine mandate to large employers.

IX. Exemptions

While the OSHA emergency temporary standard has the small employer exemption, it also exempts workers covered by the Safer Federal Workforce Task Force COVID-19 Workplace Safety: Guidance for Federal Contractors and Subcontractors. This is not a substitute for the OSH Act and should be removed from the workplace. Furthermore, OSHA uses

[18] Immunizations | ANA Position Statement | ANA Enterprise (nursingworld.org)
[19] Vaccine Exemptions (aafp.org)
[20] Medical Versus Nonmedical Immunization Exemptions for Child Care and School Attendance | American Academy of Pediatrics (aappublications.org)

Executive Order 14043 instead. I oppose both exclusions on the grounds that OSHA should be implementing the requirements directly. Furthermore, OSHA exempts workers covered by the healthcare ETS. I disagree with this exemption, as well.

OSHA should impose a mandatory vaccination rule for all employees with no exemptions (other than those required by other Federal laws). This is the same route that CMS has taken with regards to healthcare workers and federal contractors have been subjected to.

X. Provision

This is being done in an alternative to my proposed Subpart U in my August 20, 2021 submission, which should be adopted with the exception that the following sentences should be removed: “This does not apply to employees covered by the ministerial exception for a religious organization, but does cover employees exempt pursuant to policy under 29 C.F.R. 1975.6.”. Instead, the sentence should be removed.

A. Scope

Given the need for a broad scope for the policy, subpart 501(b) should be amended by removing “with a total of 100 or more employees” and paragraph (b)(2). Consequently, the section should read:

“(b) This section covers all employers with a total of 100 or more employees at any time this section is in effect, except that the requirements of this section do not apply to the employees of covered employers:

(1) Who do not report to a workplace where other individuals such as coworkers or customers are present;

(2) While working from home; or

(3) Who work exclusively outdoors.”

B. Vaccination Policy

OSHA should amend subsection (d) to eliminate the exemption to vaccination with face coverings and testing and the comment should be revised to note the rarity of such exemptions.

(d) Employer policy on vaccination. The employer must establish, implement, and enforce a written mandatory vaccination policy..

Note 1: An employee who refuses to get vaccinated may constitute a direct threat under 42 U.S.C. § 12111.

Note 2: The hardships of exposure to covid-19 may constitute more than a de minimus burden.

Note 3. Medical exemptions to the covid-19 vaccine are rare.

C. Reporting Tests

OSHA should also require tests be reported promptly.and contact tracing to stop workplace outbreaks.

(h) Employee notification to employer of a positive COVID-19 test and removal. Regardless of COVID-19 vaccination status or any COVID-19 testing required under paragraph (g) of this section, the employer must:

(1) Require each employee to promptly notify the employer when they receive a positive COVID-19 test or are diagnosed with COVID-19 by a licensed healthcare provider;

(2) Immediately remove from the workplace any employee who receives a positive COVID-19 test or is diagnosed with COVID-19 by a licensed healthcare provider and keep the employee removed until the employee:

(i) Receives a negative result on a COVID-19 nucleic acid amplification test (NAAT) following a positive result on a

COVID-19 antigen test if the employee chooses to seek a NAAT test for confirmatory testing;

(ii) meets the return to work criteria in CDC's "Isolation Guidance" (incorporated by reference, § 1910.509); or

(iii) Receives a recommendation to return to work from a licensed healthcare provider;

(3) Report the results of the test to the local public health authority responsible for contact tracing as soon as feasible and OSHA within 8 hours; and

(4) Cooperate, and require employee cooperation, with any contact tracing efforts.

Note 1 to paragraph (h)(2): This section does not require employers to provide paid time to any employee for removal as a result of a positive COVID-19 test or diagnosis of COVID-19; however, paid time may be required by other laws, regulations, or collective bargaining agreements or other collectively negotiated agreements.

D. Additional Requirements

I strongly urge OSHA to issue the permanent rule on the healthcare emergency.temporary standard I urge my August 20, 2021 submission to

be adopted as the final standard for both the ETS and the final rule. I demand a hearing to be scheduled as soon as possible under both rules, and that OSHA take immediate action to issue a final rule as specified.

XI. Conclusion

OSHA should immediately, or if OSHA refuses to act, the reviewing court should order OSHA to hold a formal virtual hearing on the healthcare emergency temporary standard that I requested on June 21, 2021, pursuant to section 6(b) of the OSH Act, then issue a final rule within sixty days of that hearing being concluded. Pending such action, this rule should be modified by invaliding the under 100 employee exemption as well as the federal contractor and healthcare worker exemptions from subpart 501, and remove the weekly test in lieu of a mandatory vaccination policy option.

Signed,

/s/ Theo Allen

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